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the CHILD

ATTITUDES TOWARD MINORITY GROUPS

Their Effect on Social Services for Unmarried Mothers

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MINORITY GROUPS include people lacking the physical, cultural, economic, or social characteristics of those who have achieved status, power, and prestige. Our culture, in spite of its heterogeneity, is a "white, Anglo-Saxon, male, Protestant culture in many respects."

If we accept these characteristics, women, children, organized labor, unmarried mothers, as well as certain religious, non-white and cultural groups are minorities. In this frame of reference, minority denotes lower status rather than fewer numbers.

In trying to avoid the misuse of the term "race" we use the term "culture" to designate groups of people that differ from other groups. By culture we mean the historically developed patterns of family organization, language, customs and traditions, beliefs, worships, sanctions, and repressions that guide and direct human conduct. We regard as cultural groups people from other countries whose customs, family organization, etc., differ from ours; for example, Spanish speaking people, Japanese, and Chinese.

The American Negro has the same basic cultural heritage as other Americans. His cultural patterns have been developed on American soil and in close relation to the white group. An important body of historical material substantiates the fact that there is very little left of his African heritage.

Actually, there is no well-defined American cultural pattern. There are definite outlines as in a common language, family organization, and our theoretical ideas of a democratic society. Within this framework are wide variations—perhaps more variations than conformity when it comes to concepts of marriage and family and the actual organization of our social life.

Whatever the minority group, there are certain common attitudes toward them. These attitudes are the crystallization of some underlying assumptions and traditionally accepted values. Rarely are they based on facts or on experience. The characteristics of a single individual are applied to the group, for example, "Women are ruled by their emotions"; "men should be paid more than women"; "all Negroes can sing"; "Jews are aggressive"; "Indians are silent and sullen."

Many reasons have been advanced to explain such prejudices. They include: A social order based on a profit-making system in which there is a limitless urge to exploit the means of production; economic insecurity expressed in competition for jobs; emotional insecurity that needs a socially acceptable outlet for anxiety and hostility; economically and socially disadvantaged groups, who in order to protect their own egos need to find other groups that they can feel superior to; fear and distrust, physical differences and resistance to change.

The behavior of persons in minority groups is thought of as growing out of inherent physical and biological traits. Actually, it represents an attempt to organize the life and values of the group so as to permit the most satisfying functioning in the social setting to which the group has been assigned.

This kind of generalizing leads to certain expectancies of behavior. For example, Negroes are *expected* to have children born out of wedlock. Indians are expected to be lazy and lacking in ambition. Such generalizations lull us into complacency about many of our social problems.

Minority groups are considered inherently inferior. Traditional patterns of segregation and discrimination are based on this assumption. In turn, the minority groups tend to take over the attitudes and values of the dominant group. Hence they *feel* inferior, insecure, and frustrated.

It is in this framework of attitudes and public opinion that social welfare programs, including those for unmarried mothers, must be projected.

Based on paper given at the National Conference of Social Work, held Apr. 17–23, 1948, at Atlantic City, N. J.

How community attitudes affect services

Social welfare programs for all people are affected by prevailing community attitudes toward dependency, certain types of behavior, and social break-down. The acceptance of broader responsibility by government, local, State and national, for the welfare of people, and the growing consciousness of the responsibility for providing public social services to people needing the service regardless of their economic status, is evidence of the progress we have made. Nevertheless the feeling that people in need are somehow different from those not known to social agencies still persists.

As our understanding of human behavior has increased, our approach to all social problems including unwed motherhood has been on a sounder basis and certainly more humane. However, the social stigma on unmarried mothers still remains and makes the experience traumatic and fearful—fraught with guilt and anxiety. The attitudes of family, friends, the community are the sources from which spring the major social problems faced by unmarried mothers.

Within minority groups, unmarried mothers suffer guilt and shame as in the majority group. In a study made of Indian unmarried mothers known to a voluntary social agency on the West Coast, it was found that the majority of the mothers were nonresidents. In asking why they had come to this city the girls gave the same reasons given by American white girls in similar studies. They were getting away from the hostile attitudes of families, friends, and community or seeking adequate medical care. There are variations in attitude toward unwed motherhood in minority groups as in the majority group. Unwed motherhood among native whites in the hills of Kentucky or the "Jeeters" of "Tobacco Road" does not have the

same connotation as on Beacon Hill in Boston.

To provide adequate services for unmarried mothers, as well as for others, there must be basic public services in local communities where people live. These include broad social services for people in need of the services without regard to economic status, color, religion, or national origin. Medical services and financial aid are also part of these basic public services.

Through the Social Security Act, Federal financial help has been given to the States in providing, extending and strengthening these basic public services.

Frequently communities are not aware that responsibility is not being assumed for all their children, although this responsibility has been given by law to public agencies—and assumed through articles of incorporation by many voluntary agencies. For example, a southern city where Negroes make up 25 percent of the population has had a program of care for white children for 50 years, but it was not until 9 years ago that the community was awakened to its responsibility for Negro children by a study which pointed up their needs.

Maternal and child health services are a resource for unmarried mothers and their babies as well as for other mothers and in general are provided without distinction as to color, religion, or national origin. Unfortunately these services are not available in every local community.

Hospital care during confinement is often a problem for unmarried mothers in minority groups. In large cities, where there are public hospitals, facilities are usually provided for minority groups. In small towns and rural areas, hospital facilities are inadequate for all groups, but almost totally lacking for minority groups. Private hospitals as a rule restrict their services or admit only a limited number of persons in minority groups.

Financial aid is available to minority groups

Aid to dependent children is made available to children without discrimination on the basis of color, religion, or national origin. In general, assistance is also made available to unmarried mothers for their children.

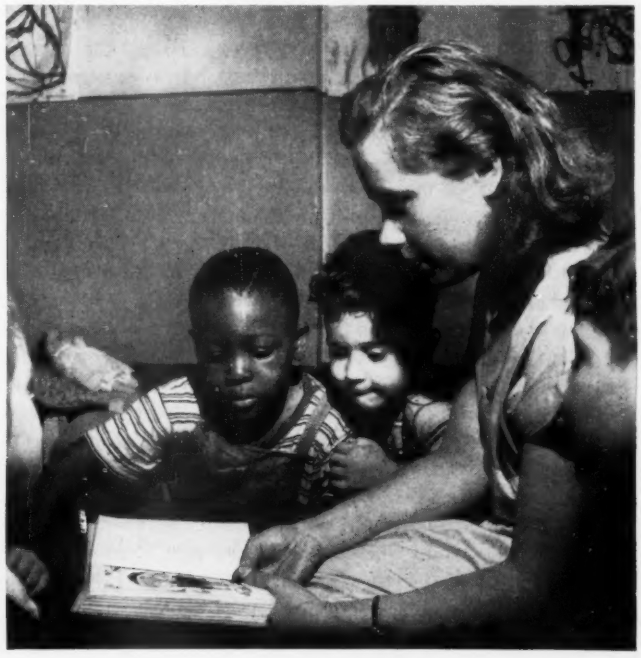
State and local administration of aid to dependent children is influenced by the prevailing community attitudes. Because the majority of persons in minority groups are also generally in the lowest income groups it is sometimes presumed that their needs are less and that naturally they are able to live on less money. Although there are standard budgets which vary from State to State, the application of the budget to specific families is influenced by the attitudes, concern, and conviction of State and local administrators and the community.

Case-work service is basic

Skilled case-work service is basic to adequate social services. Child-welfare services developed in each State under the Social Security Act offer a resource for case-work services to help unmarried mothers work through their difficulties. Unfortunately child-welfare services are not everywhere available. Where services do exist, theoretically these are given on the basis of need without distinction as to color, religion, or national origin. Actually, however, children in minority groups receive less than do other children.

There are many reasons for this but community attitudes are basic to all. When, because of shortage of personnel, child-welfare workers must carry large case loads, the more emergent situations, and those on which the community is demanding action, get first consideration. When communities are complacent or unconcerned about conditions under which children in minority status are living, there is no demand for action. Even though these children are eligible for services and many of them need help, they do not come to the

Children are less apt to be prejudiced and can get along together if their elders do not set barriers and influence their thinking and behavior.



attention of the public child-welfare agencies.

Private family and children's agencies offering services to unmarried mothers vary in their assumption of responsibility to persons in minority groups. Often their articles of incorporation define and limit the groups they serve, for example to persons of Jewish, Catholic, or Lutheran faiths. Nonsectarian agencies, however, usually are not limited by constitution or charter as to color, nationality, or religion. The extent to which they extend their services is dependent upon the enlightenment and progressiveness of their boards and executives. In cities of borderline, northern Midwest, and Western States, usually services are extended to those who need them without question. In some southern cities, however, the needs of Negroes are untouched by private agencies.

Social worker's attitudes are important

Frequently social workers are not aware of their responsibility to serve all children and to give leadership in reaching children in minority groups. They are often just as unaware as the community of the social needs of these children.

In the field of social work developing a professional self involves not only the accumulation of a body of knowledge and skills, but the use of one's *self* in a disciplined way in helping people. This has specific significance in work with people in minority groups.

Social workers like other people are the products of their inherited endowments and their experiences in family and community living. The disciplines of their professional training often bring them into sharp conflict with old ways of feeling and thinking; but should furnish conviction that leads to action on the basis of new knowledge and increased understanding. It is this last step that is so difficult to take in the face of contra-prevailing attitudes.

This is not confined to social workers in the majority group. Persons in minority groups who have taken on the cultural pattern of the majority group are often insecure and hold on to their hard won gains most tenaciously. Assuming the attitudes of the majority group tends to make for closer identification with that group. Often the distance between the lowest and highest social classes within the minority group is greater than the distance between the majority and minority groups on the same economic and social level.

To be effective in a case-work relationship, we need to understand the cultural background of our client. But to understand the client as an *individual*, we must be aware of the meaning his experiences have had for him. Using the words of Bertha Reynolds, this cultural background "is like the backdrop of a stage against which the drama of the individual is to be played."

Good foster homes for children in minority groups *can* be found and should be used more often.

Availability of facilities is affected by social attitudes

The availability of facilities for minority groups is frequently affected by complacency about social problems within those groups and also by unfounded, generalized thinking. As a result their needs are frequently ignored and disregarded in establishing social-welfare programs. For example, a county judge refused to authorize county funds for boarding-home care for Negro unmarried mothers because he believed that Negroes always care for their children, and therefore, boarding-home care was not needed. Social workers are not free from such fallacious thinking. As late as 1944, a report coming to the Children's Bureau stated: "It was the general opinion of the child-welfare workers of X county that Negro families care for Negro children when something happens to their parents and that the neighborliness and kindliness of Negro relatives far exceed that of white relatives. Therefore, there is very little need for foster care for dependent Negro children." Even though there was some essence of truth here, real concern should compel us to question the kind of care these children receive and should lead us to assume the same degree of responsibility for safeguarding the welfare of these children as for others.

Maternity home facilities are inadequate

Few maternity homes include girls from minority groups. Some Mexican, Chinese, Japanese, and Indian girls are accepted in western cities, but not Negro girls. A few maternity homes serve Negro unmarried mothers exclusively.

Some maternity home boards and executives in recent years have attempted to face this situation realistically. The immediate problem is the inadequacy of facilities for all unmarried mothers. What is needed here is reevaluation of maternity home care in terms of its ob-

jectives and the unmarried mothers who will profit from such care. Such planning should precede any extension of maternity home care.

With careful evaluation of individual needs it may be found that some girls will best be cared for in their own homes or with relatives, others in foster homes, and others in maternity homes. Adequate case-work services should be available wherever the unmarried mother is. The experience gained in planning a total program of care for all unmarried mothers will furnish a sound basis for attacking the problem of maternity home facilities for Negro girls.

Another problem in relation to maternity home care for unmarried mothers in minority groups is the belief that the community is not ready to accept the intermixture of races in the homes. Some communities are not. Some have legal barriers against this. But in communities where there are no legal barriers, who can say how far the community is ready to go? Salvation Army maternity homes in Chicago and New Jersey accept Negro girls although other institutions in these communities do not.

Some maternity homes fear that if they open their doors to girls from minority groups, they will become segregated institutions serving only the minority groups. Such fears are unfounded. Young people are less apt to be prejudiced and get along together if their elders do not set barriers and influence their thinking and behavior. If the maternity home has a sound program of services, referring agencies will want this service for white girls, too, and the girls will seek it for themselves.

Foster homes are needed

Foster homes for care of unmarried mothers, especially those in minority groups, are being used increasingly. The difficulty usually expressed in providing such care is in finding adequate homes. True, the majority of people in minority groups are in the lowest income groups, live in the poorest sections in substandard dwellings and with much overcrowding. However, not all persons in minority groups live under these conditions and often it is possible to find homes adequate for this purpose.

Can our failure to find foster homes in the minority group be due to generalized thinking that prevents a factual determination of what is available? How effective are we in making people in minority groups aware of our need for homes? Do these people know what our programs are, and how we can help unmarried mothers?

Sometimes services are not used

One serious problem encountered in providing services for unmarried mothers in minority groups is that they do not use the services. The frequency of independent placements of children of unwed mothers in this country indicates that this problem is not confined to minority groups. The situation, however, may be more acute among them.

The most damaging result of minority status is that these groups are cut off from the main current of community life. They have no feeling that the community will provide for them and little consciousness of the community's responsibility for them. When services are established they are often unaware that the service is there, or that it is for them. At the same time those providing the service may not be aware of this psychological gulf.

Thus to establish a service is not enough. Persons responsible for its administration must see to it that the service is known and help persons in minority groups to use it.

Here efforts must be directed to finding, developing, and utilizing the strengths and leadership within the group. This leadership may be found in just an ordinary person, or it may be the minister, teacher, club woman, or businessman. They should serve on boards and committees, and participate in program and policy making decisions. Through such participation they gain an understanding of agency programs and in turn can help persons in their own group in using the services.

The use of professional personnel from minority groups is also important. This does not mean that only Negroes can serve Negroes, or only Indians can serve Indians. An emotionally mature professionally trained person recognizes the necessity for understanding the client as an individual, within his cultural setting and will be able to form a constructive relationship with any client. However, the agency's inclusion on its staff of persons other than white demonstrates to the community its purpose to serve all people. They not only bring an increase in requests for service from minority groups, but they are an effective educative force with other staff members.

Since community attitudes are determining factors in providing adequate services for unmarried mothers, what is our responsibility as social workers?

We must first have the conviction that community attitudes are not static, that they are dynamic, can be directed, and do change. We must be convinced that we have a responsibility for leadership and for change. We must be aware of our own blind spots and prejudices. We must face the fact that we frequently use the excuse that the "community is not ready" in order to hide our own fears, lack of conviction and courage. We must attempt to see all people as individuals. We must abandon the tendency toward generalizing about groups of people. We must analyze objectively why we are ineffective in a given situation. We must not excuse our failure through blind and wishful thinking that "this is part of the culture pattern, and we dare not disturb it."

We must understand the emotional damage that segregation and discrimination fosters—and we must tell the story in our day by day contacts on the job; to our friends; and to others with whom we are associated. We must assume leadership with our boards and advisory groups in bringing them to the acceptance of their full responsibility. We must take leadership in the integration of persons in minority groups on boards, committees, and staffs. And all of this must be done, not on the emotional basis of race or moral judgment, but on the firm professional basis of giving the best possible service to all persons needing the service.

The cornerstone of social work is the belief in the integrity and worth of the human personality. We believe that the welfare of the individual is the goal of a democratic society. If we are not imbued with the spirit of our profession, if we lack the courage of our convictions, then social work itself has no substance and meaning.

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WHAT ARE THE TRENDS IN CHILD-GUIDANCE CLINICS?

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COINED IN 1922, the term "child-guidance clinic" gave a name to an idea that was already 13 years old. The term was used for the first time in demonstrations fostered by the Commonwealth Fund for the National Committee for Mental Hygiene to characterize a threefold clinical service that drew on different professional skills. But much had happened before that.

Dr. William Healy, who founded the Chicago Juvenile Psychopathic Institute in 1909, utilized the findings of psychiatrist, psychologist, and social worker. At the Boston Psychopathic Hospital, which opened in 1912, Dr. E. E. Southard used the term "clinical team" and made use of all the skills available for his patients. In New York, in 1922 at the Bureau of Children's Guidance of the New York School of Social Work and in demonstration clinics conducted by the National Committee for Mental Hygiene and in 1927 at the Institute for Child Guidance the threefold clinical approach became fully effective.

The first psychiatric work with children in the United States emphasized the prevention of delinquency. Healy's work in Chicago and Boston gave it this direction. But the child-guidance clinics rather quickly broadened the base of the work by treating children in their own environments.

The chief aims of the early clinics seem to have been making a thorough diagnosis of the child's difficulties and trying to influence the conditions surrounding him. Dr. Milton E. Kirkpatrick cites another early objective as helping children who showed undesirable behavior and personality traits to achieve "such a quality of mental health that they would be saved from serious mental disorder later in life."[1]

In 1934, Dr. George S. Stevenson and Geddes Smith described the work of the clinic as an attempt to marshal sources of help in a community for certain of its children. These children were in distress because of unsatisfied inner needs or because they were seriously at odds with their environment. Clinical services were given to selected children by means of direct study and treatment by a team made up of a psychiatrist, a psychologist, and a psychiatric social worker. By giving out the results of its first-hand study of some children, the clinic attempted to reveal to the community the unmet needs of many other children.[2]

Many of the problems that the early clinics had to consider were not directly connected with delinquency or mental disease. Difficulties, perhaps of a minor nature, received attention because they occurred frequently, because they were more promising of successful treatment, or because they were potentially serious. During this time the categories of emotional and behavioral difficulties were ascertained from practical experience.

In the child's orbit

A period followed in which clinics emphasized diagnosis. They soon realized that to deal with a child's difficulties they must reckon with his environment. At that time, because placing children in settings different from their usual ones had proved disappointing or impracticable, interest centered on work with persons closest to the child. This interest, perhaps at first aimed at instructing parents, teachers, and others in the child's orbit, soon drew them in as assistants in the effort to help. Then, confronted with the personal complexity of these potential assistants and with their limitations, the clinic team naturally tried to find effective ways of working with them. They focused on treatment methods and much of the work in the clinics during the past 15 years has been developing therapeutic methods and procedures.

The concept of the child has changed

Outstanding in the history of child guidance and a profound influence on clinical methods is the change in our concept of the child. According to Dr. Frederick H. Allen no longer are children regarded as automatons, reflecting unhealthy attitudes of others and incapable of change except as conditions in which they live are changed. In early clinical efforts, Dr. Allen writes, the child was examined and tested mainly to gain information about him rather than to help him directly with his emotional problems. The child was seen as a victim of conditions. Now he is seen as a dynamic factor in his own growth. He takes an active part in the process designed to bring about for him a better adjustment.[3]

Child-guidance clinics have contributed much to the development and refinement of treatment methods, but a discussion of the techniques of psychotherapy is not our immediate concern. We are interested in the way the clinics have utilized the progress made over the years. Differences in practice in the various clinics, it should be said, are not caused by differences in their philosophies of treatment but rather by differences in the method through which collaboration is achieved between the various members of the working team.

That work should proceed with child and parents concurrently is commonly agreed today. Parents and child have had a part in creating the problem for which help is sought and all will have a part in solving it. This does not imply that a clinic cannot admit a parentless child or one away from his family. Most clinics prefer, however, to have responsibility for the child made clear, in the absence of parents. The substitute for the child's parents, like the parents themselves, will influ-

[1] The Organization and Function of the Child Guidance Clinic. The National Committee for Mental Hygiene, 1941.

[2] Child Guidance Clinics, A Quarter Century of Development. The Commonwealth Fund, Oxford University Press, 1934.

Based on paper given at the National Conference of Social Work, held April 17–23, 1948, at Atlantic City, N. J.

[3] Developments in Child Psychiatry in the United States. American Journal of Public Health, September 1948.

Shy and lonely, she needs the help of a clinic as much as does a defiant, misbehaving child.

ence the course of treatment of the child and should be included in the procedure.

Application procedure

The so-called "application procedure" or "initial planning period" brings about the first contact between the clinic and the parents or parental substitutes. If only one parent comes at first, some clinics try to bring both parents into the contact, to take part jointly in the undertaking. In these first visits the parents learn how the clinic works. They may discuss the child's difficulty as they see it, in order to decide whether his is the kind of problem the clinic is ready to help with. In certain clinics the parents return for a second interview or for several so that their decision to accept the clinic's help is thoroughly considered and work with the child may begin under favorable circumstances. Part of the discussion centers on ways to prepare the child for the coming experience.

Distributing professional skills

An initial planning period is arranged in most clinics. Beyond application, differences in practice appear. They may be illustrated by two methods of distributing the skills of the three-member clinical team.

One group of clinics recognize a hierarchy in which the psychiatrist is the key figure in the treatment. The more disturbed or more neurotically involved individual, regardless of his position in the family, is seen usually by the psychiatrist. Thus, the psychiatrist may work with the child while the caseworker works with the parents, or vice versa. Sometimes both parent and child may be under treatment by psychiatrists. This division of work between psychiatrist and social worker calls for an early evaluation of the situation and early planning of treatment.

An illustration of this type of arrangement may be seen in an agency in which the proportion of time given by psychiatrists is less than in most of the clinics. The effectiveness of the case worker as a member of the team is extended by the closeness of the supervision given her work by the psychiatrist. The diagnosis and plan for treatment are made jointly. The case worker administers the therapy with the psychiatrist playing a systematic role in the conduct of cases through regular consultations. Close, continuous collaboration of psychiatrist and case worker underlies the whole clinical program.

Another group of clinics make the basis of their operation the difference between the nature of work with a child and that of work with a parent. According to these clinics the parent, through the application procedure, decides that he will seek help for his child by providing for him a psychotherapeutic experience, a chance to take part in an active process in which he can effect within himself essential change or psychological growth. The parent is drawn into the process himself as he learns that the clinic expects him to play an active role and as he discovers that his own attitude toward the clinic influences the child in his utilization of treatment. Work with the parent, engaged in selecting and using a clinical service for his child, falls naturally into the province of social case work. It is not artificially restricted; it will revolve around the relations of parent and child and will reach into the organization of the parent's personality.

The psychologist in the team

The distinctive contribution of the psychologist to the understanding of children has been in the field of objective evaluation. In addition to standard intelligence, aptitude, and achievement tests, psychologists now use "projective techniques," a major advance in clinical psychology. These projective techniques, perhaps the best known of which is the Rorschach, help not only to determine intellectual capacity but to reveal the structure and functioning of the personality and to make psychiatric diagnoses.

Clinics have long made it a practice to study a child's performance in tests for leads in understanding him. But a change in a test score (when the test is repeated after a time) may show even more. It may show that through treatment a child has been able to achieve a better organization. Projective procedures are especially sensitive to such changes. As confidence develops in these newer techniques they will be used more widely in prognosis. Dependence on such technical procedures can be hazardous, however, unless they are sound and are expertly applied.

Diagnosis today

Some clinics have shifted the emphasis in their diagnostic work. Previously they had looked on diagnosis as a process that oriented their approach to a problem. They could outline treatment or make plans for a child by means of the technical penetration of the problem that was possible through the pooling of professional skills. Clinics learned that parents' incapacity to utilize recommendations called for greater therapeutic efforts. The team looked with less esteem on diagnostic measures that, because of parents' shortcomings, often failed to lead to effective action, but grew to respect more the therapeutic work planned to deal with such re-

sistances. Diagnostic procedures assume a different meaning when they are looked upon as technical services available to a parent in his efforts to understand his child.

When the findings of psychological tests or the opinions of the psychiatrist after a searching interview with the child are given to his parents for consideration, they can speculate on what is to be learned from this step in evaluation. They have elected to have the study made; they will utilize the findings as they are able. A richer use of the observation of the child calls for more extensive work with the parents. Sound diagnostic work can lead to a change in the parents' relations with their child.

Resident centers

Until recently most of the active and effective work of child-guidance clinics has been with out-patients. An application of child-guidance procedure in a somewhat different framework is seen in the resident treatment programs that have recently received increasing attention. The child's admission to the resident center and his temporary stay there are part of a treatment plan. Custody is retained by his parents or substitutes for them and their close contact with him during his stay is a feature of the procedure.

A team of professional workers operates in the resident center much as it does in an out-patient clinic, but another member is added—the resident professional worker whose province is the living setting itself. The parent visits the child regularly, according to a plan, and talks with the case worker each time.

Goals in prevention altered

A changed conception of the difficulties of children has altered our goals in prevention. We are not certain of the relation to psychosis in adult life of the many different behavioral and emotional difficulties of children who come to the clinics. Certainly, few if any of these children will develop psychotic illnesses. Although our ability to detect early malignant changes of personality has been greatly extended by the refinements in interpretation of psychological tests, we cannot predict psychotic changes before they are established in the personality.

That maladjustments in childhood are the forerunners of maladjustments and neurotic difficulties in adult life is well established. But we are on uncertain ground when we try to foretell which children will do poorly in later life.

The difficulties of childhood are so much a part of the growth process, which in turn is subject to many vicissitudes, that an evaluation at a given point cannot divine the future with certainty. We are more concerned with the child's mental health at the moment than with averting disaster in adult life. In child psychiatry the interest in mental hygiene has shifted from preventing or treating mental disease to furthering normal growth.

Child psychology a subspecialty

Child psychiatry has reached the position of a subspecialty in the field of psychiatry. It calls for distinct technical skills that education and experience in adult psychiatry do not give. During therapy a child tends to express himself through play, his natural medium. He is not impelled, as is an adult, by the immediate reality of an interview to consider his troubles directly with the therapist. The clinical symptoms encountered in children are not those seen in adults; they must be learned from direct study of children. With adult patients, events of childhood are considered in retrospect, and a psychology of childhood has been constructed that can be applied in work with adults. But that psychological scheme has not, in general, served as an example to follow in work with children.

When adults close to the child are drawn into the process of treating him, features are introduced into psychiatric work with children that only recently have had a counterpart in work with adults. The fact that the child does not himself start the search for help sharpens the dissimilarity in practice.

Special training, it follows, is necessary for this specialty. The child-guidance clinic, having taken the initiative in child psychiatry for 25 years, is the natural training ground.

All-purpose clinics

A new type of out-patient clinic has recently begun to increase in number. This is the "all-purpose" clinic that serves both children and adults. These clinics, perhaps, will prove to be suited to sparsely settled areas or small communities where operating a full-time child-guidance clinic or separate services for adults would be impracticable. Early experience showed that more of the patients were children than adults. But this proportion may change now that information about the value of psychiatric treatment is reaching more and more people.

As yet these all-purpose clinics can be viewed only as a significant trend. But they will eventually influence the practice of psychiatry. The "team" approach will be used with large numbers of adult patients. This work has been done for some time in a few clinics admitting both child and adult patients and in the collaborative clinical programs established for the armed forces during the war and now organized for veterans.

The all-purpose clinic will influence the field of psychiatry through the qualifications of the workers who man them. Basic professional education in social case work and perhaps in clinical

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In the clinic a child is helped to bring about her own change by taking part in the therapy.

HEALTH OFFICERS SET GUIDES FOR FLUORINE PROGRAM

A STEP toward deriving the greatest benefit in the use of topical fluorides to prevent tooth decay was taken at the forty-seventh annual session of the State and Territorial Health Officers Association meeting in Washington, D. C., in November of this year.

At the meeting the health officers approved a statement of principles for the use of topical fluorides in public dental programs. For some years now intensive research has been under way to take advantage of the action of fluorides in preventing dental diseases. Many studies concerned with the painting of children's teeth with fluoride solutions have demonstrated the fact that tooth decay can be reduced 40 percent by such methods. These studies, at first conducted in laboratories, have since been confirmed by extensive clinical application.

This experience has produced a single technique for the use of fluoride solutions which lends itself admirably to the mass scale approach of this public-health problem.

This year the United States Congress appropriated $1,000,000 to the U. S. Public Health Service to demonstrate in States requesting the service the method of using topical fluorides. Three-fourths of the States, the Territories, and the District of Columbia have requested this demonstration service. It is believed that practically all areas of the country will become interested in the use of topical fluorides as a preventive of childhood tooth decay. In the report of the Appropriations Committee of the House of Representatives last year, it was stressed that this demonstration program was to be of a temporary nature, with the States and local communities establishing a more permanent program.

The statement of principles approved by the State and Territorial Health Officers grew out of the recognition that such widespread interest and application of a preventive measure should have a standard or guide in order to be of maximum effectiveness.

In approving the statement, the State Health Officers recommend that all public-health dental programs for children

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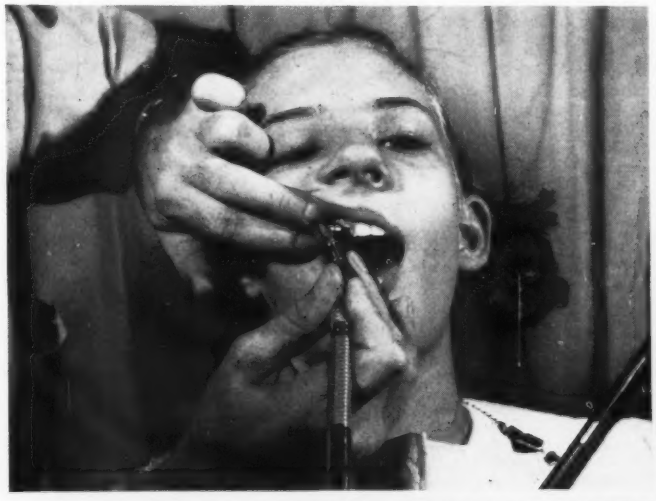
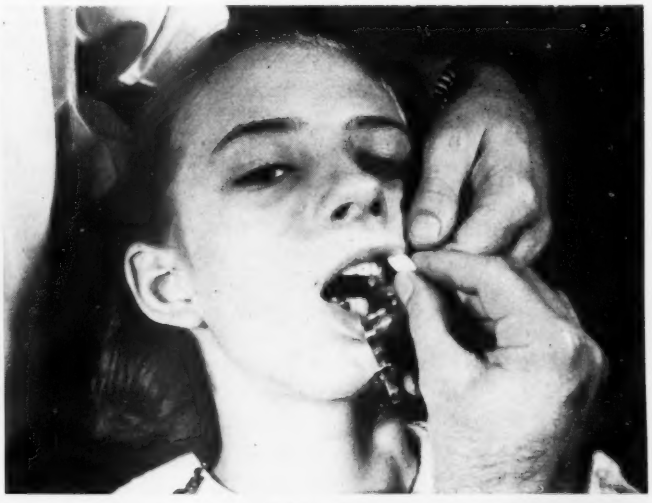
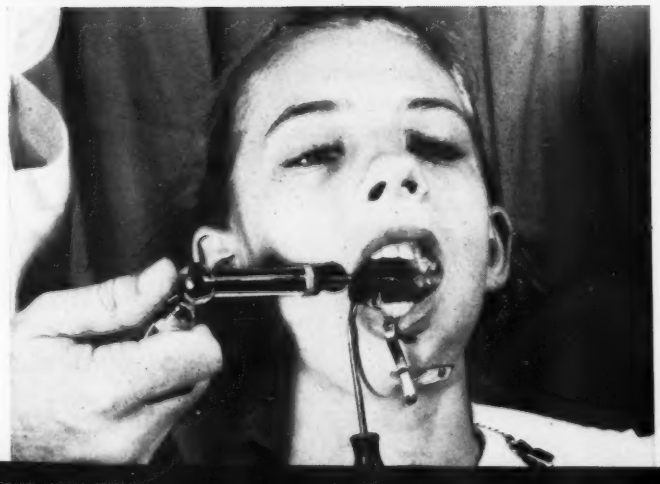
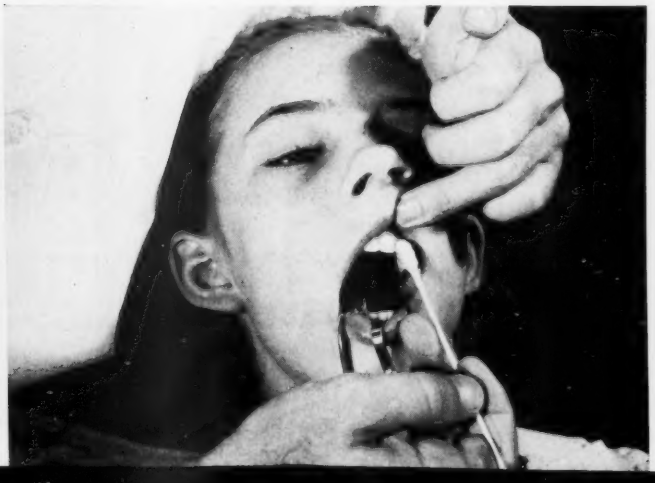
Steps in fluoride therapy. From left to right, top row: clean the teeth; block-off teeth with cotton rolls; bottom row: dry teeth with compressed air; apply fluoride solution.









THE TOLL OF RHEUMATIC FEVER

THE importance of rheumatic fever as a cause of mortality in childhood has been stressed in recent discussions from all parts of the world, and particularly in the United States. Every year between 800 and 900 children under 20 years of age die in the United States from acute rheumatic fever, not including the deaths reported from chronic rheumatic heart diseases. Clinical experts say that between 80 and 90 percent of all deaths from heart disease among school-age children (5 through 19 years of age) are due to rheumatic infection. When these deaths are added to those actually attributed to acute rheumatic fever we find that approximately 4,000 children (under 20 years of age) die each year as a result of this disease.

A leading cause of death

Since the decline of tuberculosis and the genuine acute infectious diseases of childhood (diphtheria, scarlet fever, measles, whooping cough, etc.) heart diseases, including acute rheumatic infections, have become one of the leading causes of death among school-age children. If accidents are disregarded, heart disease and rheumatic fever combined is *the* leading cause of death among white children 10 through 14 years of age and white boys 15 through 19.

Mortality rates for the six leading causes of death (in these age groups) are given in table I in the order of the rate for males; the rank of the rate for females is given in brackets. This table shows clearly the relative importance of rheumatic fever and heart diseases at different ages in both races and sexes. Among white children in all age groups the latter conditions are a principal cause of death and are of increasing importance with increasing age.

Among nonwhite children of all ages tuberculosis takes a higher toll than heart disease plus rheumatic fever, as does pneumonia-and-influenza except among the 10–14-year-old girls. Rheumatic fever and diseases of the heart ranks fourth as a cause of death among nonwhite girls 15–19 years of age, with tuberculosis first and diseases of pregnancy second. Early child bearing in this age group of nonwhite girls might also be a contributing factor in the high mortality for both tuberculosis and heart disease.

TABLE I.—Rank of 6 leading causes of death in childhood, 5–19 years, by age, race, and sex. Average annual death rates per 100,000 population: United States, 1939–41

Leading causes of death in order of the rates for the white male	White		Leading causes of death in order of the rates for the nonwhite male	Nonwhite	
	Male	Female (rank in brackets)		Male	Female (rank in brackets)
	5–9 years				
Accidents (169–195)	39. 3	20. 0 (1)	Accidents (169–195)	42. 6	26. 7 (1)
Pneumonia and influenza (107–109, 33)	10. 2	9. 0 (2)	Pneumonia and influenza (107–109, 33)	21. 2	18. 1 (2)
Appendicitis (121)	8. 2	6. 7 (4)	Tuberculosis (13–22)	16. 4	14. 7 (3)
Rheumatic fever (58) and diseases of the heart (90–95).	2. 1 5. 5 } 7. 6	2. 4 5. 6 } 8. 0 (3)	Rheumatic fever (58) and diseases of the heart (90–95).	2. 9 9. 3 } 12. 2	3. 7 9. 3 } 13. 0 (4)
Diseases of the ear, nose, and throat (89, 104, 115).	5. 3	4. 7 (5)	Diseases of the nervous system (80–88).	6. 4	5. 3 (6)
Diseases of the nervous system (80–88)	4. 9	4. 1 (6)	Appendicitis (121)	5. 8	5. 6 (5)
	10–14 years				
Accidents	40. 9	12. 2 (1)	Accidents	56. 2	14. 5 (4)
Rheumatic fever and diseases of the heart.	2. 4 8. 8 } 11. 2	2. 5 9. 2 } 11. 7 (2)	Tuberculosis	22. 3	39. 0 (1)
Appendicitis	9. 0	6. 9 (4)	Pneumonia and influenza	17. 4	16. 3 (3)
Pneumonia and influenza	7. 0	7. 1 (3)	Rheumatic fever and diseases of the heart.	3. 8 11. 3 } 15. 1	4. 2 13. 2 } 17. 4 (2)
Diseases of the nervous system	4. 9	3. 5 (5)	Appendicitis	10. 1	7. 2 (5)
Diseases of the ear, nose, and throat	3. 3	3. 2 (6)	Diseases of the nervous system	7. 8	6. 4 (6)
	15–19 years				
Accidents	74. 1	19. 8 (1)	Accidents	98. 1	21. 1 (5)
Rheumatic fever and diseases of the heart.	1. 6 12. 7 } 14. 3	1. 4 11. 2 } 12. 6(3)	Tuberculosis	97. 2	159. 7 (1)
Appendicitis	11. 2	6. 6 (6)	Homicide (165–168)	36. 4	15. 2 (6)
Tuberculosis	10. 7	18. 9 (2)	Pneumonia and influenza	30. 0	30. 9 (3)
Pneumonia and influenza	10. 4	7. 5 (5)	Rheumatic fever and diseases of the heart.	2. 2 15. 7 } 17. 9	2. 2 21. 6 } 23. 8 (4)
Diseases of pregnancy (140–150)		11. 3 (4)	Diseases of pregnancy (140–150)		62. 3 (2)

NOTE.—The numbers in parentheses after causes of death are those of the International List, Fifth Revision of 1938: they are not repeated in the different age groups when shown before.

These figures make it plain why the campaign against rheumatic fever must be considered one of the outstanding tasks of public health. In such a campaign it is necessary to know just where the high mortality rates occur and for that purpose we must break down the total crude rates and consider various subgroups of the child population. The Children's Bureau has recently issued a statistical analysis of rheumatic fever mortality[1] in which the death rates are studied on the basis of age, race, sex, and geographic location.

Age, race, and sex differences

The age, race, and sex differences in mortality from rheumatic fever and heart disease throughout the total United States are shown graphically in figure 1; the exact rates on which the chart is based can be found in table II.

The chart shows clearly the rise in the mortality rate in each succeeding age group. This is true for both races and both sexes.

The chart also shows plainly the much higher rates for nonwhite children than white in both sexes and all age groups.

The racial difference in rheumatic fever mortality is not as great as in some other diseases which are aggravated by unfavorable socio-economic conditions, such as tuberculosis, but the pattern is sufficiently strong to suggest that a more unfavorable environment, which doubtless exists for the nonwhite group, tends to increase the risk of dying from rheumatic diseases. That is, rheumatic fever appears to belong to that group of diseases in which, besides the specific etiological agent, the social environment (here reflected in racial grouping) plays an aggravating part.

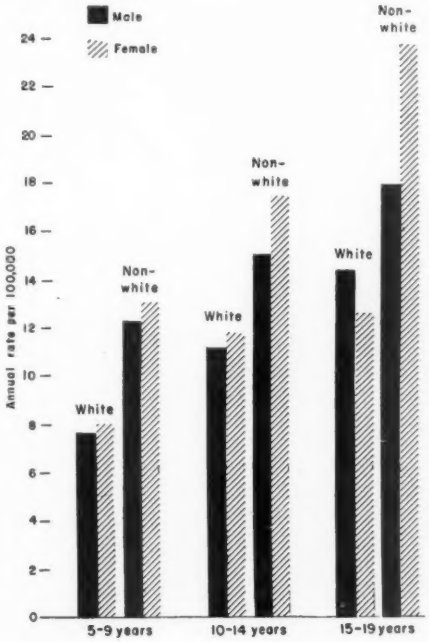
Generally speaking mortality rates from acute rheumatic fever and diseases of the heart, combined, are higher among girls than boys. A marked exception is the much lower rate for white girls as compared with white boys in the 15- to 19-year-old group. The tendency toward higher rates for girls than boys is most pronounced in the age group 15 through 19 years among nonwhite children.

[1] Childhood Mortality From Rheumatic Fever and Heart Diseases by George Wolff, M. D. Children's Bureau Publication 322. Federal Security Agency, Washington, 1948. 66 pp. 25 cents.

TABLE II.—Childhood mortality from acute rheumatic fever, chronic rheumatic diseases of the heart, and diseases of the heart (all forms), by age, race, and sex: United States, 1939–41

Cause of death and race (Numbers of International List of Causes of Death, Fifth Revision of 1938)	5–9 years		10–14 years		15–19 years	
	Male	Female	Male	Female	Male	Female
	Average annual death rates per 100,000					
Acute rheumatic fever (58), all races	2.2	2.5	2.6	2.8	1.7	1.5
White	2.1	2.4	2.4	2.5	1.6	1.4
Nonwhite	2.9	3.7	3.8	4.2	2.2	2.2
Chronic rheumatic diseases of the heart (90a, 92b, c, 93c, 95b), all races	3.2	3.4	5.4	6.0	6.7	6.0
White	3.0	3.2	5.3	5.8	6.7	5.7
Nonwhite	4.7	5.1	6.2	7.1	6.2	7.8
Diseases of the heart (all forms) (90–95), all races	6.0	6.1	9.0	9.7	13.1	12.4
White	5.5	5.6	8.8	9.2	12.7	11.2
Nonwhite	9.3	9.3	11.3	13.2	15.7	21.6
	Ratios: Nonwhite to white					
Acute rheumatic fever	1.4	1.5	1.6	1.7	1.4	1.6
Chronic rheumatic diseases of the heart	1.6	1.6	1.2	1.2	.9	1.4
Diseases of the heart (all forms)	1.7	1.7	1.3	1.4	1.2	1.9
	Ratios: Male to female					
Acute rheumatic fever:						
White		0.9		1.0		1.1
Nonwhite		.8		.9		1.0
Chronic rheumatic diseases of the heart:						
White		.9		.9		1.2
Nonwhite		.9		.9		.8
Diseases of the heart (all forms):						
White		1.0		1.0		1.1
Nonwhite		1.0		.9		.7

FIGURE 1.—Death rates for acute rheumatic fever plus diseases of the heart in white and nonwhite children, by age and sex: United States, 1939–41. (Average annual death rates per 100,000 in each specified group.)



Geographic differences

Mortality from acute rheumatic fever and diseases of the heart varies among the geographic divisions of the United States. For both white and nonwhite children, the death rates for acute rheumatic fever plus heart diseases are below average in the South while in the Northeast, especially in the Middle Atlantic division, they are significantly above average. In the Pacific division the death rates are as low as in the South and significantly below the country's average, while in the Mountain division they are exceptionally high for the white children in all age groups.

This geographic tendency becomes still more evident when rates are considered separately for white and nonwhite children or the regional differences in the proportion of white and nonwhite children are discounted by adjustment of the rates.

The crude and the adjusted rates for the geographic areas of the United States, per 100,000 children, 5 through 19 years of age, are as follows:

	Crude rates
1. Middle Atlantic	16.3
2. Mountain	15.3
3. East North Central	12.4
4. South Atlantic	11.1
5. New England	10.5
6. East South Central	10.2
7. West North Central	9.3
8. West South Central	8.8
9. Pacific	7.7

	Adjusted rates
1. Middle Atlantic	17.4
2. Mountain	15.3
3. East North Central	13.3
4. New England	12.0
5. West North Central	9.9
6. South Atlantic	9.8
7. East South Central	9.6
8. West South Central	8.4
9. Pacific	8.3

Further studies are needed to show how much of what appears to be a climatic-geographic difference in mortality may be due to differences in degree and character of urbanization or other factors. The Children's Bureau report, Childhood Mortality From Rheumatic Fever, makes comparisons of the individual States within the geographic areas. A few of the more outstanding facts of the report may be mentioned briefly.

In New England, industrial and densely populated Massachusetts shows a distinct tendency to higher mortality and is closer to the neighboring Middle Atlantic area than the other States in New England. There are no striking differences among the Middle Atlantic States except that among white children in New Jersey the boys have the lowest rates for this whole region while the girls as consistently have the highest. Why white boys should have more favorable rates in New Jersey than in New York or Pennsylvania while white girls have the most unfavorable rates among the three States cannot be answered without further study. In Indiana there is a similar situation. Here the white boys have the lowest rates and the white girls the highest to be found in the five States of the East North Central area (Ohio, Indiana, Illinois, Michigan, Wisconsin).

In the Mountain States the mortality rates in Arizona for heart disease are consistently below the group average and as consistently above in Utah. Population factors can hardly explain these differences. Similar findings have been mentioned by former investigators of the rheumatic-fever problem and they merit a more thorough examination. In particular the high mortality for 15- through 19-year-old white boys in Utah, highest among all States, challenges the attention of public-health workers and local physicians. On the Pacific Coast the highest mortality rates among white children for heart disease are found in Oregon and the lowest in California. This cannot be attributed simply to a northern climate, since Washington has better rates than Oregon, nor to overcrowding, since population density is lower in Oregon than in California; the contrast should therefore be studied more intensively locality by locality.

The trend in rheumatic fever mortality since 1920

The fact that rheumatic fever and heart disease has now become one of the leading causes of death among children is due to a decline in other childhood diseases and not to an increase in rheumatic fever mortality rates. Table

TABLE III.—Death rates for acute rheumatic fever and diseases of the heart in children, 5–19 years, by age, race, and sex: United States death registration States, 1919–21, 1929–31, 1939–41, 1942, 1943, and 1944

[Average annual rates per 100,000]*

Years, cause of death	White						Nonwhite					
	5–9 years		10–14 years		15–19 years		5–9 years		10–14 years		15–19 years	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1919–21												
Acute rheumatic fever	4.4	4.1	4.5	5.3	3.5	3.6	2.3	2.2	2.5	3.7	3.7	3.5
Diseases of the heart	14.2	15.2	18.8	23.9	23.2	23.3	8.2	10.1	14.8	18.1	22.1	30.7
1929–31												
Acute rheumatic fever	3.0	2.9	3.1	3.2	2.3	2.3	2.1	2.9	3.3	3.2	2.7	3.2
Diseases of the heart	9.6	10.6	13.4	16.4	18.5	18.4	9.6	10.4	12.9	15.0	21.1	28.2
1939–41												
Acute rheumatic fever	2.1	2.4	2.4	2.6	1.7	1.4	2.9	3.7	3.8	4.2	2.2	2.2
Diseases of the heart	5.5	5.6	8.8	9.2	12.7	11.2	9.3	9.3	11.3	13.2	15.7	21.6
1942												
Acute rheumatic fever	1.8	1.8	1.8	2.1	1.3	1.4	2.6	3.7	3.8	3.6	2.1	1.9
Diseases of the heart	4.3	4.4	6.9	6.9	11.4	10.4	7.5	8.7	12.0	10.9	15.0	19.8
1943												
Acute rheumatic fever	1.6	1.4	1.7	1.9	1.3	1.4	3.3	2.9	2.8	2.6	1.8	2.7
Diseases of the heart	4.0	4.6	7.0	7.7	11.4	9.8	4.8	7.1	11.5	13.5	15.5	23.6
1944												
Acute rheumatic fever	1.7	1.5	2.0	2.1	1.9	1.4	2.9	3.8	3.3	3.8	2.8	1.4
Diseases of the heart	3.9	4.9	7.5	7.1	11.1	8.6	6.3	7.2	11.5	12.7	15.3	18.1

III shows the death rates for acute rheumatic fever and for diseases of the heart by age, race, and sex for the period between World War I and World War II.

The most impressive fact brought out by table III is the distinct decrease in mortality among white children, reported over the past decades. This decrease is in the neighborhood of 70 percent for the age groups 5 through 9 and 10 through 14, and of 60 percent for the age group 15 through 19 years.

However, the story is very different for nonwhite children. Among these children no consistent downward trend is visible, except in the oldest age group 15–19 years; even this decrease is far behind that of the white adolescents in both sexes and amounts to hardly more than 25 percent from 1919–21 to the last report in 1944. It appears from the reported figures that in the early period (1919–21) the nonwhite children had very low death rates, lower indeed in most instances than those of the white children. This result is contrary to later experience in the detailed study of the 1939–41 period, when the nonwhite children almost everywhere demonstrate consistently higher death rates from rheumatic fever and heart diseases than the whites.

How far the statistics reflect the true epidemiological trends of rheumatic fever among white and nonwhite children during recent decades is open to question. It is improbable that the socio-economic conditions, including availability of medical services to nonwhite children, was so superior in the earlier period as to bring out these results. The most plausible explanation of the apparently increased mortality rates would seem to be that for nonwhite children the reliability of the medical diagnoses and their reporting on the death certificates has increased.

All combined (crude) rates necessarily obscure finer differences by age, race, and sex. Therefore age-race-sex specific death rates are given in the Children's Bureau report for the individual States; they provide more detailed information of special interest for the local State health authorities.

Child Guidance Clinics

(Continued from page 88)

psychology can be applied more interchangeably in work with children or in work with adults than can basic education in psychiatry. Two years of accredited training in adult psychiatry are required as preparation for advanced training given in child-guidance clinics in psychiatry for children. If his preliminary training in work with adults has been adequate, the psychiatrist trained in a child-guidance clinic can work with both child and adult patients. But because there are few so trained and because pressure from the public to have clinics established gives so powerful an incentive, some all-purpose clinics may start to operate under the direction of psychiatrists who are not satisfactorily grounded in work with children.

Interest, funds, but few specalists

A critical issue confronts the child-guidance clinic. The new, keen public interest in seeing psychiatric services extended, combined with greater availability of funds for establishing them, has created pressure for more children's clinics. Some communities, disregarding the advice of experienced counselors and undismayed by the shortage of qualified specialists, are employing workers unable to operate efficiently in a child-guidance clinic.

Fortunately, a source of help on standards is at hand for communities wanting to build a service. Recently organized, the American Association of Psychiatric Clinics for Children will serve as an accrediting agency. Acting with the Division on Community Clinics of the National Committee for Mental Hygiene, this association will provide criteria that communities may use in planning and operating clinics.

The importance of sound planning and building cannot be too strongly urged. Otherwise the high level of child-guidance practice, the source of the clinics' success for a quarter of a century, may not be maintained universally.

Reprints available in about 3 weeks

Guides for Fluorine Program

(Continued from page 89)

should routinely include the topical application of fluoride and, since it is a preventive measure of great promise, it should be available to all children in the area.

Recognizing that the services of dentists are already at a premium and so urgently needed to provide corrective dental care which only dentists are qualified to render, the statement suggests that auxiliary personnel be trained to provide the fluoride treatment. In this way, the maximum number of children can be reached.

To further promote efficiency and economy of the topical fluoride program, it was felt the service could best be provided in places where it was possible to reach groups of children, such as schools, clinics, and institutions.

The Health Officers believed that two administrative methods would be feasible: (1) Adding the topical fluoride applications to existing dental clinic services; and (2) Organizing new programs devoted exclusively to the use of fluorides, so that the services could be made available to children in areas that do not now have highly developed dental programs.

In starting a community program, the statement of principles points out, a series of 4 sodium fluoride applications should be given to every child in the community. Thereafter, in order to provide protection for the permanent teeth during the period of changing dentition, the series of 4 applications should be repeated at approximately 3-year intervals.

The statement concludes with the suggestion that a technic which has been adequately tested should be rigidly followed.

The Children's Bureau, responsible in the Federal Government for administration of grants to the States for child-health services, has already approved the use of these grants for providing this essential dental service for children. It is anticipated that the States will request increasing amounts of child-health grants to help finance State-wide protection of children's teeth by the new method.

• WHITE HOUSE CONFERENCE PLANNING

Progress Notes on State Action

TAP ROOTS of action toward the 1950 White House Conference are spreading wider and deeper over the country. "Nation-wide" begins to have real meaning as the concept of a mid-century stock taking of America's children grips the minds and imaginations of people; as States and communities set to work to stimulate action toward objectives to be achieved by 1950.

At this time 35 States have some form of planning committee or council for children and youth, some officially established, others on a voluntary basis. At least three other States or Territories are in process of organizing a planning group.

Since January 1, the following State councils and commissions either have been established or strengthened:

Arizona Youth Council.
Colorado Council for Youth, Inc.
Kentucky Planning Committee for 1950 White House Conference.
Illinois Council for Children and Youth.
Michigan White House Conference Preparatory Committee, and Michigan Interdepartmental Committee on Child Services.
Oregon Governor's State Committee on Children and Youth.
West Virginia Committee on Planning for Children and Youth.
Wisconsin Committee on Planning for the White House Conference.
Wyoming Council on Children and Youth.

A number of States, at the call of their Governors, have held State conferences on children and youth. Some of these are specifically called and so designated, in preparation for the 1950 White House Conference. Others are that in essence but not so designated. They all denote a growing awareness of the necessity to build stronger services for children and youth.

The result of this coordinated planning for children is a growing unity of effort between the public and private agencies, between professionals and laymen—a partnership in the common cause of children.

Michigan in action

"Children are everybody's business." With that as its title, the Governor of Michigan called a conference on children and youth in Lansing, November 11, 12, and 13. In June, Governor Sigler had appointed two committees: One the Interdepartmental Committee on Child Services, made up of 12 State agencies dealing with children, and the other the White House Conference planning committee. These two committees did the spade work for the conference.

Success of the conference, and all reports confirm that it was a success, was due, as one commentator puts it, "to cooperation and communal brain work." Nearly 800 persons jammed the general sessions; there were over 600 registered delegates. During the conference, 66 sessions were held, 7 regional conferences, and 21 discussion groups. Prof. Jay Bryan Nash of New York University was the keynote speaker at the opening and the closing sessions.

The conference laid the foundation for State-wide action for children. Karl F. Zeisler was chairman of the planning committee for the conference.

Maine starts planning

The Maine State Conference of Social Work, meeting in November at Bangor, instructed the chairman, Dr. Burton Taylor, of the Department of Sociology of Bowdoin College, to take action, in cooperation with other groups, to further Maine's planning for the White House Conference. An informal planning group met in conference for this purpose on December 3.

Ohio conference in process

Too late to be reported, a State-wide conference on children and youth was held in Ohio, December 15. The conference expected to recommend organization of a permanent State committee with a paid director. Gov. Thomas J. Herbert, in calling this conference, wrote:

"In this period of world-wide uncertainty and change, it is imperative that we in Ohio give serious thought to the preparedness and the conservation of our human, as well as our material, resources. Inasmuch as the children and youth of Ohio are the State's basic resources, we must assay how adequately the needs of children are being met at the present time and must plan to improve facilities for child care so that every child will reach adult life equipped to fulfill his duty to society....

"Such steps will be in line with planning for the White House Conference for Children which will be called in 1950 for the purpose of evaluating the child-care facilities and programs in operation in the various States."

North Carolina looks at children

At a meeting September 28, which brought together lay citizens, including a group of young people, and representatives of private and governmental agencies, Gov. R. Gregg Cherry designated the North Carolina Conference for Social Service as the agency to sponsor North Carolina's participation in the 1950 White House Conference. A steering committee was set up to assist the president and secretary of the North Carolina Conference for Social Service to carry forward plans and initiate action.

The impetus for this conference came from the report, "What of Children in North Carolina?" issued in 1947 by the State Planning Board's committee on services for children and youth. The North Carolina Commission on Statutes Relating to Domestic Relations, authorized by the legislature in 1947, has been at work drafting bills embodying the recommendations made in the report.

Reports made at the September conference presented concretely a picture of how North Carolina has embarked upon the task of finding out about the status of its children and services to them and what it proposes to do about bettering the services.

A committee on projects outlined a wide range of projects for study and promotion. The first step is to be a stock-taking survey by each community of its resources, facilities, programs,

and needs for children. This would be a follow-up of the comprehensive State survey on tax-supported services for children and general social and economic facts about children reported under the title of "What of Children in North Carolina?"

A proposed program of legislation affecting children, to be presented to the 1949 State legislature, was also outlined to the conference.

This conference was one of a series planned to insure State-wide discussion of the measures proposed.

State and county action in Texas

Texas has set in motion a county-by-county program in preparation for the White House Conference. The Texas Committee for Children and Youth held its annual meeting November 16 in Houston. Howard Lackey, Executive Secretary of the Community Council of San Antonio, was elected chairman of the committee. Mrs. George H. Abbott, former chairman, will continue to be responsible for work with the county White House Conference chairmen.

Kansas council meets

The Kansas Council on Children met in Topeka, October 27. The council is working with the Juvenile Code Commission to interpret the commission's legislative proposals to the public.

Initial planning in Iowa

The Division of Public Health Education called a meeting October 6 to consider: "How Will Iowa Prepare for the 1950 White House Conference on Children and Youth?" Mr. King Palmer of the Iowa Mental Hygiene Society was selected as chairman of the preliminary planning committee and Miss Esther L. Immer of the State board of social welfare, secretary.

Minnesota youth conference

Minnesota's fine State-wide program for youth was reported on at the Governor's State Conference on Youth held in St. Paul, October 18–19. In calling the meeting, Gov. Luther W. Youngdahl said, "No more important meeting has been called since I became Governor."

This is only a partial reporting of the action in behalf of children and youth which is going on in the Nation. Citizen groups are at work reviewing the needs of children and preparing measures to be presented to State legislatures meeting in 1949.

Patterns of action begin to emerge throughout the country in preparation for the Midcentury White House Conference on Children.

The character of planning toward the conference is essentially democratic. Its main strength lies in local initiative and experience to be gained through diversity. While plans and procedures vary, one common purpose binds all who engage in this national enterprise—to strive to reach the maximum that every State and community, and the Nation, can achieve for the good of children.

• QUOTE-UNQUOTE

"There is a growing group of agricultural migrants in this country who are largely responsible for the high quality of fruits and vegetables that we find in our markets the year round. Many of these migrants move in family groups and their children often help on the crops. Our States and communities have not yet built up a system of assuring to these migrant families the protection and services that are available to the permanent residents of communities. Frequently, mothers have little care at the time of childbirth, children have no health services, little schooling and no access to community recreation facilities; and their families are housed in unsanitary shacks and camps, often without adequate protection from the weather. Progress has been made, but the problem of providing conditions and services for these families comparable to those we consider essential in a good American community has not yet been attacked with sufficient vigor by communities, States, or the Federal Government."

Program for Children and Youth, adopted by the National Commission on Children and Youth, January 28–30, 1948.

"America is faced with a solemn obligation. Long ago we promised to do our full part. Now we cannot ignore the cry of hungry children. Surely we will not turn our backs on the millions of human beings begging for just a crust of bread. The warm heart of America will respond to the greatest threat of mass starvation in the history of mankind."

Julia C. Lathrop, 1919.

• CALENDAR

Dec. 27–29—American Statistical Association. Cleveland, Ohio.

Dec. 28–30—American Sociological Society. Chicago, Ill.

Dec. 28–30—American Economic Association. Cleveland, Ohio.

Dec. 28–30—American Political Science Association. Chicago, Ill.

Area conferences, National Child Welfare Division, American Legion:

Dec. 9–11, 1948. Area E—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. Hollywood, Calif.

Jan. 7–8, 1949. Area D—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. Milwaukee, Wis.

Feb. 11–12, 1949. Area B—Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, and West Virginia. Baltimore, Md.

Mar. 4–5, 1949. Area A—Connecticut, Maine, Massachusetts New Hampshire, Rhode Island, and Vermont. Boston, Mass.

Mar. 11–12, 1949. Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Jackson, Miss.

Regional conferences, Child Welfare League of America:

Feb. 10–12, 1949. Southern Regional Conference. Montgomery, Ala.

Mar. 17–19, 1949. Ohio Valley Regional Conference. Cincinnati, Ohio.

Apr. 7–9, 1949. Eastern Regional Conference. Atlantic City, N. J.

May 1–4, 1949. Midwest Regional Conference. Chicago, Ill.

June 6–7, 1949. New England Regional Conference. Portsmouth, N. H.

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THE ROAD AHEAD TO CHILD HEALTH

Most of us are aware that we are living in a period of great change; in a new age growing out of man's skill in discovering facts about the physical and biological world and his ingenuity in applying them. We cannot escape from the fact that knowledge in this realm has surged far ahead of knowledge in the social sciences of the nature of man himself. Enormous benefits to our health, to our social and economic status, may accrue; but so too may our destruction come out of scientific advance. What we have failed to grasp is that the use to which these tools are put by man will be determined by his social philosophy, by his emotional reactions and behavior.

Man has learned that he must nurture the land if it is to be productive, he must tend it carefully and wisely, he must fertilize it. So must our health programs develop from cultivation at the grass roots. The vigor of our State and national health services will depend upon the nurture we give to local health activities.

What man will be like when he comes to maturity will depend to a great extent upon the nurture we give him in his infancy and early childhood, upon the opportunities and guidance we give him in his adolescence and youth, upon the strength we develop in the relationship of parent to infant, parent to child, child to child. In a very real sense the child is the touchstone. What we do for him we do for all mankind; what we do for adults, we also do for children.

Children must become the focus of our everyday thought, of our economic and social planning, and of our domestic and foreign policy. Suppose we limit ourselves to child health. What does this mean in the field of health?

There are some parts of the maternal and child health program we know how to do fairly well, but we are not doing them well enough nor extensively enough. I refer specifically to the basic preventive program in which the physician and the nurse advise the mother, either in the physician's office, or in the health center, or in the school or clinic, or at home, about the health and general care of herself, her baby, and her children. Hundreds of thousands of parents still do not have this help; few parents get the best help we know how to give, including pediatric, nursing, dental, nutrition, and social advice; very few receive the kind of mental advice that pediatric workers trained in child development are equipped to give.

Basic maternal and child health services, however, are not enough. Many additional services are urgently needed. Mothers must have complete and adequate maternity care available to them everywhere. Infants, especially those prematurely born, all preschool children, and children of school age through adolescence must have freely available to them, wherever they live, not only preventive health services, mental as well as physical, but also all necessary care when they are sick, and child guidance and psychiatric service when required. Unless we have these services, we cannot produce a generation of young people who are fully mature and healthy in body and mind, who are emotionally secure and able to give more than is asked for, to face success and frustration with equanimity, to be self-reliant, to cooperate with their fellows, to take their place in a democratic society as thoughtful, responsible citizens concerned with the common good, and to "live harmoniously in a total changing environment."

This is the kind of harvest for which we must now cultivate our soil and husband our resources.

Martha M. Eliot
Associate Chief, Children's Bureau

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